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End-Stage Renal Disease Program

Health Care Financing Administration

COMPLETED 61

Instruction Manual for Renal Providers

IES 41

ORIGINAL

Program Management and Medical Information System

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U.S. Department of Health and Human Services
Margaret M. Heckler, *Secretary*

Health Care Financing Administration
Carolyne K. Davis, Ph.D., *Administrator*

Bureau of Data Management and Strategy
Regina McPhillips, Dr. P.H., *Director*
James M. Kaple, Ph.D., *Deputy Director*

Office of Statistics and Data Management
Eugene I. Stickler, *Director*

Division of Information Analysis
Charles R. Fisher, *Director*

End-Stage Renal Disease Systems Branch
James A. Dunnigan, *Chief*

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End-Stage Renal Disease Program

Health Care Financing Administration

Instruction Manual for Renal Providers

Program Management and Medical Information System

U.S. Department of Health and Human Services
Health Care Financing Administration
Bureau of Data Management and Strategy
Baltimore, Maryland
August 1985

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Purpose of Manual

The Instruction Manual for Renal Providers was created to assist Medicare-approved renal providers in preparing and submitting the non-reimbursement end-stage renal disease data collection forms necessary to the operation of the national ESRD program Management and Medical Information System (PMMIS).

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DESCRIPTION OF ESRD DATA COLLECTION FORMS

The forms described in this Manual are utilized to gather data for the End-Stage Renal Disease (ESRD) Program Management and Medical Information System (PMMIS). All Medicare-approved renal providers are required by law (section 405.2133 of Subpart U of the Code of Federal Regulations) to complete these forms on a timely basis.

These forms are listed below.

HCFA-2728-U4, Chronic Renal Disease Medical Evidence Report

This form is to be completed once the patient is diagnosed as having end-stage renal disease. It requires a physician's signature certifying that the patient has ESRD. The information captured from this form will identify new patients filing for ESRD Medicare benefits. This form is available from the local social security office or the social worker at the renal provider.

HCFA-2744, ESRD Facility Survey

This form is completed annually by all Medicare-approved renal providers. This form is sent to each provider by the Network office.

HCFA-2745-U3, ESRD Transplant Information

This form is completed by all Medicare-approved renal transplant providers within 2 weeks of the date of transplant. A supply of these forms should be available at all transplant providers; if not, they may be obtained by calling the Network office.

Transplant Follow-up Form

This form is completed by all Medicare-approved renal transplant providers at the time the transplant recipient is discharged from the hospital following the transplant surgery. A supply of these forms should be available at all transplant providers; if not, they may be obtained by calling the Network office. Subsequent Transplant Follow-ups are to be completed 6 months post-transplant, 1 year post transplant, and yearly thereafter. These Follow-ups are to be completed by the transplant provider or attending physician, if different from the transplant surgeon. Transplant Follow-ups must be completed as long as the patient lives and the transplanted kidney functions.

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HCFA-2746, ESRD Death Notification

This form is completed by the primary provider of care within 2 weeks of the date of death of an ESRD patient, regardless of where the death occurred. A supply of these forms should be available at all Medicare-approved renal providers; if not, they may be obtained by calling the Network office.

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ESRD FORMS TO BE SUBMITTED TO THE NETWORK OFFICES

Form	Completed By	When to Complete	Where to Submit copies of Forms
HCFA-2728-U4 Chronic Renal Disease Medical Evidence Report	Attending physician	Once the patient is diagnosed as having ESRD	WHITE copy: Send to servicing social security office BLUE and YELLOW copies: Send to Network GREEN copy: Retain in provider
HCFA-2744 ESRD Facility Survey	Transplant centers and dialysis units	Annually	Send completed Survey to Network
HCFA-2745-U3 ESRD Transplant Information	Transplant centers	Within 2 weeks following date of transplant	PINK and YELLOW copies: Send to Network WHITE copy: Retain in provider
ESRD Transplant Follow-up Form	Transplant centers initially; transplant centers or attending physicians subsequently	At time of discharge from hospital following transplant surgery; at 6 months post-transplant; at 1 year post-transplant; yearly thereafter (until patient dies, the transplanted kidney fails or the patient is lost-to-follow-up)	Send completed form to Network
HCFA-2746 ESRD Death Notification	Tansplant center or dialysis unit which was last responsible for care of patient on an ongong basis, regardless of place of death	Within 2 weeks following date of death	GREEN and YELLOW copies: Send to Network WHITE copy: Retain in provider

These forms will be verified by Network staff and questionable items will be resolved before the Network submits them to the ESRD Support Section in Baltimore, Maryland, for inclusion in the ESRD PMMIS.

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The Chronic Renal Disease Medical Evidence Report, HCFA-2728-U4, is to be completed once the patient is diagnosed as having end-stage renal disease. It requires a physician's signature certifying that the patient has ESRD. The information captured from this report will identify new patients filing for ESRD Medicare benefits. (See note below.)

The original (WHITE) is to be sent to the local servicing social security office.

The second (BLUE) and third (YELLOW) copies are to be sent to the Network office. The Network will forward the blue copy to the ESRD Support Section and will retain the yellow copy for its files.

The fourth (GREEN) copy is to be retained by the provider.

NOTE: The HCFA-2728-U4 is a Medicare entitlement related form. Listed below are various situations covering the completion/submission of the initial or second HCFA-2728-U4.

1. An initial HCFA-2728-U4 must be completed and submitted on every newly diagnosed ESRD patient, including those who may already be entitled to Medicare based on old-age or disability.

2. A second HCFA-2728-U4 must be completed on an ESRD patient who, having had a "successful" kidney transplant for 36 months or longer (and, therefore, terminated for Medicare ESRD purposes), must return to dialysis because of transplant failure (i.e., must reapply for Medicare based on ESRD).

3. A second HCFA-2728-U4 need not be completed for an ESRD patient who undergoes a transplant or enters a self-dialysis training course after the 3-month qualifying period has passed. However, if the transplant or self-dialysis training occurs during the qualifying period, the ESRD patient may be eligible for earlier Medicare entitlement. If this dialysis training or transplant information had not been reported on the initial HCFA-2728-U4, then a second HCFA-2728-U4 should be completed.

4. A second HCFA-2728-U4 need not be completed when a patient changes his/her treatment modality or treatment setting, unless it is to report a transplant or enter a self-dialysis training course during the 3-month qualifying period.

5. We are aware of situations where the Social Security Administration (i.e., local social security offices) requires that HCFA-2728-U4's be completed when an ESRD patient receives a transplant, voluntarily stops dialysis, or regains kidney function. Because the Social Security Administration may be using this form to compute possible termination of Medicare ESRD benefits 36 months after the transplant occurs or 12 months after dialysis stops, the renal transplant and dialysis centers must comply with this requirement. When a HCFA-2728-U4 is completed for this purpose after Medicare entitlement has been established, do not forward copies of the form to the Network office. Instead, forward the original and all copies of the form to the local social security office.

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CHRONIC RENAL DISEASE MEDICAL EVIDENCE REPORT

NO MEDICARE BENEFITS MAY BE PAID UNLESS THIS FORM IS RECEIVED AS REQUIRED BY EXISTING LAW AND REGULATIONS (42 C.F.R. 405.104). INDIVIDUALLY IDENTIFIABLE PATIENT INFORMATION WILL NOT BE DISCLOSED EXCEPT AS PROVIDED FOR IN THE PRIVACY ACT OF 1974 (5 U.S.C. 552a; 45 C.F.R. PART 5b).

IDENTIFYING INFORMATION

1. PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	2. PATIENT'S OWN SOCIAL SECURITY NUMBER
3. PATIENT'S ADDRESS (STREET, CITY, ZIP)	4. PATIENT'S CLAIM NUMBER
5. PHONE NO. * / 6. COUNTY OF RESIDENCE *	7. DATE OF BIRTH
8. ADDRESS OF SOCIAL SECURITY OFFICE	9. PATIENT'S SEX * ☐ a. MALE ☐ b. FEMALE
10. RACE * ☐ a. AMERICAN INDIAN OR ALASKAN NATIVE ☐ b. ASIAN OR PACIFIC ISLANDER ☐ c. BLACK ☐ d. WHITE ☐ e. UNKNOWN	11. ETHNICITY * ☐ a. HISPANIC ☐ b. NON-HISPANIC

12. NAME, ADDRESS, AND PHONE NUMBER OF PHYSICIAN RESPONSIBLE FOR RENAL TREATMENT AT TIME OF CLAIM

13. PRIMARY DIAGNOSIS (CAUSE OF ESRD) **	14. SECONDARY DIAGNOSIS *

TREATMENT INFORMATION—DIALYSIS

TYPE OF DIALYSIS	DATE REGULAR DIALYSIS BEGAN	FREQUENCY SINCE REGULAR DIALYSIS BEGAN (TIMES PER WEEK)	HAS DIALYSIS ENDED?	IF ENDED, DATE OF LAST DIALYSIS
15a ☐ HEMODIALYSIS	15b	15c	15d ☐ YES ☐ NO	15e
16a ☐ PERITONEAL	16b	16c	16d ☐ YES ☐ NO	16e
17. NAME OF DIALYSIS PROVIDER			18. DIALYSIS PROVIDER NUMBER	

TREATMENT INFORMATION—TRANSPLANT

19. DATE(S) OF TRANSPLANT	20. WAS THE PATIENT IN A HOSPITAL IN PREPARATION FOR, OR ANTICIPATION OF, A KIDNEY TRANSPLANT PRIOR TO THE DATE OF ACTUAL TRANSPLANTATION? ☐ YES ☐ NO		21. IF YES, ENTER DATE(S)
22. NAME OF HOSPITAL FOR ITEM 21	PROVIDER NO.	23. NAME OF TRANSPLANT HOSPITAL IF DIFFERENT FROM ITEM 22	PROVIDER NO.
24. CURRENT STATUS OF TRANSPLANT (IF b. CHECKED, ANSWER 25 OR EXPLAIN IN REMARKS) ☐ a. FUNCTIONING ☐ b. REJECTED	25. DATE OF RETURN TO REGULAR DIALYSIS	CURRENT TREATMENT SITE ☐ a. HOME ☐ b. FACILITY	

MEDICAL CERTIFICATION

26. DO YOU CERTIFY THAT THIS PATIENT HAS REACHED THE STATE OF RENAL IMPAIRMENT THAT APPEARS IRREVERSIBLE AND PERMANENT AND REQUIRES A REGULAR COURSE OF DIALYSIS OR KIDNEY TRANSPLANTATION TO MAINTAIN LIFE? ☐ YES ☐ NO	SIGNATURE AND TITLE OF ATTENDING PHYSICIAN	DATE

CERTIFICATION OF SELF CARE DIALYSIS TRAINING

27. NAME, ADDRESS OF TRAINING PROVIDER	PROVIDER NO.	28. DATE TRAINING BEGAN	29. TYPE OF TRAINING ☐ a. HEMODIALYSIS ☐ b. PERITONEAL ☐ c. CAPD
30. HAS THE PATIENT COMPLETED THE TRAINING PROGRAM? ☐ YES ☐ NO	IF NO, WHEN IS THE PATIENT EXPECTED TO COMPLETE THE PROGRAM?		31. DO YOU CERTIFY THAT THE PATIENT IS EXPECTED TO COMPLETE TRAINING SUCCESSFULLY AND SELF DIALYZE ON A REGULAR BASIS? ☐ YES ☐ NO

32. I CERTIFY THAT THE ABOVE SELF DIALYSIS TRAINING INFORMATION IS BASED ON CONSIDERATION OF ALL PERTINENT MEDICAL, PSYCHOLOGICAL, AND SOCIOLOGICAL FACTORS AS REFLECTED IN RECORDS KEPT BY THIS TRAINING FACILITY, AND IS CORRECT.

SIGNATURE OF PHYSICIAN PERSONALLY FAMILIAR WITH THE PATIENT'S TRAINING	TITLE	DATE

33. REMARKS

34. I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, AGENCY OR OTHER ORGANIZATION TO DISCLOSE TO THE SOCIAL SECURITY ADMINISTRATION FOR PURPOSES OF REVIEWING MY APPLICATION FOR MEDICARE ENTITLEMENT UNDER THE SOCIAL SECURITY ACT, ANY MEDICAL RECORDS OR OTHER INFORMATION ABOUT MY MEDICAL CONDITION.

SIGNATURE OF PATIENT (SIGNATURE BY MARK MUST BE WITNESSED)	DATE

FORM HCFA-2728-U4 (6-81)

*NOT REQUIRED TO OBTAIN A BENEFIT, WILL BE USED FOR STATISTICS ONLY

**NOT REQUIRED TO OBTAIN A BENEFIT, BUT MUST BE COMPLETED FOR PURPOSES OF PROGRAM ADMINISTRATION

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INSTRUCTIONS FOR COMPLETING THE CHRONIC RENAL DISEASE MEDICAL EVIDENCE REPORT, HCFA-2728-U4

ITEM	PROCEDURE
1	Patient's Name (Last, First, Middle Initial) (To be completed by the patient or someone acting for the patient.) Enter the patient's name (last, first, middle initial.)
2	Patient's Own Social Security Number (To be completed by the patient or someone acting for the patient.)
3	Patient's Address (Street, City, Zip) (To be completed by the patient or someone acting for the patient.) Enter the patient's mailing address (street number, city, state, and zip code).
4	Patient's Claim Number (To be completed by the patient or someone acting for the patient.) If the patient is a recipient of monthly social security benefits, enter the claim number (social security number and appropriate suffix) on which he or she is entitled.
5	Phone No. (To be completed by the patient or someone acting for the patient.) Enter the patient's home telephone number.
6	County of Residence (To be completed by the patient or someone acting for the patient.) Enter the name of the county (if any) in which the patient resides. If patient's residence is not in a specific county, enter incorporated city or township.
7	Date of Birth (To be completed by the patient or someone acting for the patient.) Enter patient's date of birth.

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8 Address of Social Security Office
(To be completed by social security office.) Enter the address of the social security office servicing the claim.

9 Patient's Sex
(To be completed by the patient or someone acting for the patient.) Check the appropriate block to identify sex.

10 Race
(To be completed by the patient or someone acting for the patient.) Check the appropriate block to identify race. Definitions of the basic racial categories for Federal statistics are as follows:

American Indian or Alaskan Native: A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

Asian or Pacific Islander: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

Black: A person having origins in any of the black racial groups of Africa.

White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Unknown: Check this block if race is unknown.

11 Ethnicity
(To be completed by the patient or someone

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acting for the patient.) Check the block which identifies the ethnicity of the patient, as described below:

Hispanic Origin: A person of Mexican, Puerto Rican, Cuban, Central or South American, or othe Spanish culture or origin, regardless of race.

Non-Hispanic: A person of culture or origin not described above, regardless of race.

12 Name, Address, and Phone Number of Physician Responsible for Renal Treatment at Time of Claim
(To be completed by the patient or someone acting for the patient.) Enter the name, office address, and telephone number of the physician who is supervising the patient's renal treatment.

13 Primary Diagnosis (Cause of ESRD)
(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) Enter the primary diagnosis established at the time it was determined that the patient required dialysis treatment (i.e., primary diagnosis causing ESRD).

14 Secondary Diagnosis
(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) Enter the secondary diagnosis established at the time it was determined that the patient required dialysis treatment.

15a Type of Dialysis—Hemodialysis
(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) If the patient is, or was, on regular hemodialysis, check this block and complete items 15b through 15e.

16a Type of Dialysis—Peritoneal
(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) If the patient is, or

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was, on regular peritoneal dialysis, check this block and complete items 16b through 16e. If the patient is, or was, on continuous ambulatory peritoneal dialysis (CAPD), check this block, insert "CAPD" in 16a, and complete items 16b through 16e.

17 Name of Dialysis Provider
(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) Enter the name of the dialysis facility.

18 Dialysis Provider Number
(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) Enter the provider number (6-digit Medicare identification code) of the dialysis facility. If the dialysis facility is not a Medicare-approved renal dialysis facility, leave this item blank.

19 Date(s) of Transplant
(To be completed by the physician supervsing the patient's kidney treatment or someone acting for the physician.) Enter the date(s) of the patient's kidney transplant(s).

20 Was the Patient in a Hospital in Preparation for, or Anticipation of, a Kidney Transplant Prior to the Date of Actual Transplantation?
(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) Check the appropriate block to indicate whether or not (prior to the month of transplant) the patient was in a hospital for transplant or for necessary procedures preliminary to transplant.

21 If Yes, Enter Date(s)
(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) If the answer to item 20 was "yes," enter the date(s) of hospitalization.

22 Name of Hospital for Item 21
(To be completed by the physician supervising

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the patient's kidney treatment or someone acting for the physician.) Enter the name and provider number of the hospital the patient entered for the dates in item 21.

23 Name of Transplant Hospital if Different from Item 22

(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) If different from item 22, enter the name and provider number of the hospital where the kidney transplant occurred.

24 Current Status of Transplant

(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) Check the block which indicates the current status of the transplant. If 24b is checked, item 25 should be completed.

25 Date of Return to Regular Dialysis/Current Treatment Site

(To be completed by the physician supervising the patient's kidney treatment or someone acting for the physician.) If the transplant rejected, enter the date the patient began a regular course of dialysis and indicate the current dialysis setting.

26 Do You Certify that this Patient Has Reached the State of Renal Impairment . . .?

(To be signed by the physician supervising the patient's kidney treatment.) This medical certification question must be answered by the physician, and his/her signature and title must appear in this item. Enter the date signed.

27 Name, Address of Training Provider/Provider Number

(To be completed by the physician familiar with the patient's self-care dialysis training or someone acting for the physician.) Enter the name, address, and provider number of the provider furnishing self-care dialysis training. This item is to completed if the patient is

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applying for a waiver of the qualifying period for dialysis based on participation in self-care dialysis training.

28 Date Training Began

(To be completed by the physician familiar with the patient's self-care dialysis training or someone acting for the physician.) Enter the date self-dialysis training began. This item is to be completed if the patient is applying for a waiver of the qualifying period for dialysis based on participation in self-care dialysis training.

29 Type of Training

(To be completed by the physician familiar with the patient's self-care dialysis training or someone acting for the physician.) Check the appropriate block which describes the type of self-care dialysis training the patient began. This item is to be completed if the patient is applying for a waiver of the qualifying period for dialysis based on participation in self-care dialysis training.

30 Has the Patient Completed the Training Program?

(To be completed by the physician familiar with the patient's self-care dialysis training or someone acting for the physician.) Check the appropriate block as to whether or not the patient has completed the training program. If the answer is "No," enter the date the patient is expected to complete the training program. This item is to be completed if the patient is applying for a waiver of the qualifying period for dialysis based on participation in self-care dialysis training.

31 Do You Certify that the Patient Is Expected to Complete Training . . .?

(To be completed by the physician familiar with the patient's self-care dialysis training or someone acting for the physician.) Check the appropriate block as to whether or not the physician certifies that the patient is expected to complete the training successfully and

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self-dialyze on a regular basis. This item is to be completed if the patient is applying for a waiver of the qualifying period for dialysis based on participation in self-care dialysis training.

32 I Certify that the Above Self-Dialysis Training is Based . . .

(To be signed by the physician familiar with the patient's self-care dialysis training.) This certification of self-care dialysis training must be signed by the physician personally familiar with the patient's training. The physician's title and the date signed should also be entered. This item is to be completed if the patient is applying for a waiver of the qualifying period for dialysis based on participation in self-care dialysis training.

33 Remarks

Use this space for explanations of answers to other items on the report or for furnishing additional information such as the date of a scheduled transplant.

34 I Hereby Authorize Any Physician, Hospital, Agency, or Other Organization to Disclose to the SSA . . .

The patient's signature authorizing the release of information to the Social Security Administration should be secured here. The date signed should also be entered.

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ESRD Facility Survey, HCFA-2744

The ESRD Facility Survey is completed annually by all Medicare-approved renal providers. The survey period is January 1 through December 31. These forms are mailed to the providers by the Network offices. Upon completion, the form is returned to the Network office.

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Form Approved
OMB No. 0938-0064

END—STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM
ESRD FACILITY SURVEY

FOR THE PERIOD

PATIENTS DIALYSIS EDITS

Field 01 + ... 03 =
Field 03 - (04A thru 07B) + (08A thru 13B) = Field 22
Sum of fields 14 thru 21 = field 22
Sum of fields 23 thru 26 = 27
Sum of fields 29 thru 31 = field 28

PART ONE - DIALYSIS

Patients Receiving Care Beginning of Survey Period

In-Unit	Home	Total Fields 01 thru 02
01	02	03

Additions During Survey Period

	Started for first time ever	Restarted	Transferred from other dialysis unit	Returned after transplantation
In-Unit				
Home				
	04A 04B	05A 05B	06A 06B	07A 07B

Losses During Survey Period

Deaths	Recovered kidney function	Received transplant	Transferred to other dialysis unit	Discontinued therapy	Other (LTFU)
08A 08B	09A 09B	10A 10B	11A 11B	12A 12B	13A 13B

Patients Receiving Care at End of Survey Period

Staff assisted dialysis		In-Unit Self Dialysis		Self Dialysis Training				Total In-Unit	Home Patients				Total Home	Total Patients
Hemodialysis	Peritoneal dialysis	Hemodialysis	Peritoneal Dialysis	Hemodialysis	Peritoneal Dialysis	CAPD	CCPD	Fields 14 thru 21	Hemodialysis	Peritoneal Dialysis	CAPD	CCPD	Fields 23 thru 26	Fields 22 and 27
14	15	16	17	18	19	20	21	22	23	24	25	26	27	28

Patient Eligibility Status End of Survey Period

Currently enrolled in Medicare	Medicare application pending	Non-Medicare
29	30	31

Self-Dialysis Patients Completing Training

Home hemodialysis	In-Unit Self Hemodialysis	Home peritoneal dialysis	In-unit self peritoneal dialysis	CAPD	CCPD
32	33	34	35	36	37

Transient Patients

Treated during survey period	No. of treatments during survey period
38	39

TREATMENT LOAD

In-Unit Dialysis Treatments

Hemodialysis			Peritoneal dialysis		
Inpatient	Outpatient Staff-Assisted	Outpatient In-Unit Self	Inpatient	Outpatient Staff-Assisted	Outpatient In-Unit Self
40	41	42	43	44	45

Dialysis Training Treatments

Hemodialysis	Peritoneal dialysis	CAPD	CCPD
46	47	48	49

COMPLETED BY (Signature)	DATE	TITLE	TELEPHONE NO.
VERIFIED BY (Signature)	DATE	TITLE	

REMARKS REGARDING INFORMATION PROVIDED ON THIS SURVEY SHOULD BE ENTERED ON THE LAST PAGE OF THIS SURVEY

This report is required by law (42 USC 426, 42 CFR 405.2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 USC 552a, 45 CFR, Part 5a).

Form HCFA-2744 (9-84) (Formerly HCFA-600-6)

Department of Health and Human Services
Health Care Financing Administration

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Form Approved
OMB No 0938-0064

END—STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM
ESRD FACILITY SURVEY

FOR THE PERIOD

PATIENTS/TRANSPLANTS-EDITS

Sum of fields 54 and 55 = field 56 and field 71
Sum of fields 51 thru 53 = field 50

PART TWO - KIDNEY TRANSPLANTS

Patients who received transplant at this facility	Eligibility Status of Patients Transplanted at this Facility During the Survey Period		
	Currently enrolled in Medicare	Medicare application pending	Non-Medicare
50	51	52	53

Transplants Performed at This Facility		
Living donor	Cadaveric donor	Total fields 54 thru 55
54	55	56

Patients Awaiting Transplant	
Dialysis	Non-dialysis
57	58

CADAVER KIDNEYS

Source of Cadaver Kidneys	Disposition of Cadaver Kidneys			
	Transplanted at this facility	Sent to another facility	Not used	Total
Harvested at this center	59	60	61	62
Obtained from another transplant hospital	63	64	65	66
Obtained from non-transplant hospital	67	68	69	70
Total	71	72	73	

COMPLETED BY (Signature)	DATE	TITLE	TELEPHONE NO
VERIFIED BY (Signature)	DATE	TITLE	

REMARKS REGARDING INFORMATION PROVIDED ON THIS SURVEY SHOULD BE ENTERED ON THE LAST PAGE OF THIS SURVEY

This report is required by law (42 USC 426; 42 CFR 405.2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 USC 552a; 45 CFR Part 5a).

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END—STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM ESRD FACILITY SURVEY	FOR THE PERIOD

PART THREE

REMARKS:

This report is required by law (42 USC 426; 42 CFR 405.2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 USC 5520; 45 CFR, Part 5a).

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ESRD FACILITY SURVEY
INSTRUCTIONS FOR COMPLETION

REPORTING RESPONSIBILITY

The ESRD Facility Survey is designed to capture only a limited amount of information concerning each Federally approved renal facility's operation. It is not intended to yield information on the full range of ancillary services or activities, e.g., referrals, graft outcome, etc. These concerns are more appropriately and validly addressed by the network in supplemental requests o through other segments of the Medical Information System.

Every facility/center certified by Medicare to provide services to ESRD patients must furnish the information requested in the ESRD Facility Survey (42 USC 426; 20 CFR 405, Section 2133).

Survey Period

The Facility Survey is completed annually. The survey period is January 1 through December 31.

This Facility Survey is to be completed for the period January 1, 1984 through December 31, 1984. Unless specified otherwise, all data entered on the Facility Survey is to cover the entire survey period. The form should be completed and forwarded to the local ESRD Network, at the following address:

GENERAL INSTRUCTIONS

For purposes of this document, the word "facility" will be used interchangeably when referring to renal dialysis facilities, renal dialysis centers, or renal transplant centers, as applicable.

All patient and treatment counts requested are to include only the diagnosed chronic ESRD population; no reversible failure patients or treatments may be counted.

All diagnosed chronic ESRD patients treated at the facility should be counted and reported as (1) regular, continuing caseload (field 03); (2) added to the regular caseload (fields 04A through 07B); (3) lost from the regular caseload (fields 08A through 13B); or (4) transient (field 38).

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Transient, seasonal, temporary transfers for inpatient care or vacation are reported in two ways. The usual (3 months, 51 percent or more of treatment/supervision) facility counts the patient as part of regular caseload; the facility that treats/supervises the patient episodically (less than 3 months or less than 51 percent) counts the patient (one time only if multiple transfers have occurred) in field 38.

Inclusion of patients in counts should not depend on entitlement determination; newly diagnosed chronic unit admissions should be included, both for peritoneal or hemodialytic therapy and transplantation.

PART ONE

(FOR COMPLETION BY DIALYSIS UNITS ONLY)

I. PATIENT LOAD

Patients Receiving Care Beginning of Survey Period

Field 01: In-Unit. Enter the number of patients dialyzing in your facility at the beginning of the survey period. This number should reflect your "permanent" patient population; that is, those patients for whom your facility had ongoing medical responsibility for the routine care of the patient until he/she was formally transferred elsewhere. Therefore, this number should include those of your routine patients who were hospitalized or were in transient status away from your facility at the beginning of the survey period. (This number should equal the total of fields 14 through 20 from the previous survey submitted.)

Field 02. Home Enter the number of patients followed by your facility (that is, for whom your facility had the major medical responsibility) who were dialyzing at home (hemodialysis, peritoneal dialysis, continuous ambulatory peritoneal dialysis, or continuous cycling peritoneal dialysis) at the beginning of the survey period. (This number should equal the sum of fields 21 through 23 from the previous survey submitted.)

Field 03: Total. Enter the sum of fields 01 and 02. This is to equal the number of patients on your facility's register at the beginning of the survey period. (This number should be the same as that reported in field 24 from the previous survey submitted.)

Additions During the Survey Period

NOTE: This section requires counts for additional in-unit and home dialysis patients accepted during the survey period. A PATIENT SHOULD NOT BE COUNTED IN MORE THAN ONE FIELD as an addition in fields 04A through 07B. Count them in the field which describes the last status if more than one is applicable.

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Newly Diagnosed Patients:

Field 04A: In-Unit--Started for the First Time Ever. Enter the number of newly diagnosed ESRD patients who were admitted to your facility as chronic maintenance dialysis patients for the first time ever during the survey period. This is a count of patients who have begun their initial course of maintenance dialysis therapy at your facility during the survey period. Do not include patients who transferred to your facility from another dialysis facility; that data is to be reported in field 06A. Include in field 04A patients who began their initial course of maintenance dialysis therapy at a non-approved renal provider and transferred to your facility during the survey period.

Field 04B: Home--Started for First Time Ever. Enter the number of newly diagnosed ESRD patients who, after being stabilized on dialysis, successfully completed a course of self-dialysis training and began home dialysis (their initial course of dialysis after training) during the survey period. If they are still in training at the end of the survey period, report them in field 04A.

Restarted Dialysis:

Field 05A: In-Unit--Restarted. Enter the number of patients who restarted in-unit dialysis during the survey period; e.g., persons who had temporarily recovered kidney function, discontinued dialysis, or had been lost to follow-up and have since restarted routine in-unit dialysis.

Field 05B: Home--Restarted. Enter the number of patients who restarted home dialysis during the survey period. These are patients who had temporarily recovered kidney function, discontinued dialysis, or had been lost to follow-up and have since restarted regular home dialysis.

II. Transferred From Another Facility:

Field 06A: In-Unit--Transferred from Other Dialysis Unit. Enter the number of patients admitted to your facility who were formally transferred from another facility during the survey period and who are continuing a regular course of dialysis at your facility.

Field 06B: Home--Transferred from Other Dialysis Unit.
Enter the number of home patients who were formally transferred by another facility during the survey period to your unit for ongoing medical supervision and responsibility.

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Returned After Transplantation:

Field 07A: In-Unit--Returned After Transplantation. Enter the number of patients who returned to in-unit dialysis during the survey period after a transplant failure.

Field 07B: Home--Returned After Transplantation. Enter the number of patients who returned to home dialysis during the survey period after a transplant failure.

Losses During the Survey Period

NOTE: These fields describe losses to your facility of both in-center and home dialysis patients that occurred during the survey period. A PATIENT SHOULD NOT BE COUNTED IN MORE THAN ONE FIELD from field 08A through 13B. For purposes of this survey, "in-unit" includes patients who routinely dialyzed in-unit at the time of loss to the reporting facility, and "home" includes patients who routinely dialyzed at home at the time of loss to the reporting facility. Count patients in the field which describes the last status if more than one is applicable.

Deaths:

Field 08A: In-Unit--Deaths. Enter the number of in-unit dialysis patients who died during the survey period. (These deaths must be shown here by the facility if the patients were reported in fields 01, 04A, 05A, 06A, or 07A.)

Field 08B: Home--Deaths. Enter the number of home dialysis patients who died during the survey period. (These deaths must be shown here by the facility if the patients were reported in fields 02, 04B, 05B, 06B, or 07B.)

Recovered Kidney Function:

NOTE: These are diagnosed chronic renal failure patients who recovered renal function.

Field 09A: In-Unit--Recovered Kidney Function. Enter the number of patients who recovered kidney function and ceased chronic ESRD in-unit dialysis during the survey period.

Field 09B: Home--Recovered Kidney Function. Enter the number of patients who recovered kidney function and ceased chronic home ESRD dialysis during the survey period.

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Transplanted:

Field 10A: In-Unit--Received Transplant. Enter the number of patients who received a kidney transplant and left the in-unit dialysis program during the survey period.

Field 10B: Home--Received Transplant. Enter the number of patients who received a kidney transplant and left the home dialysis program during the survey period.

Transferred Out:

Field 11A: In-Unit--Transferred to Other Dialysis Unit. Enter the number of in-unit dialysis patients who permanently transferred to another dialysis facility for their ongoing dialysis during the survey period; that is, those patients whose ongoing, routine medical supervision became the responsibility of another dialysis facility.

Field 11B: Home--Transferred to Other Dialysis Unit. Enter the number of home patients who had been followed by your facility but who are now permanently followed by another home dialysis program.

Discontinued Dialysis:

Field 12A: In-Unit--Discontinued Dialysis. Enter the number of chronic patients who permanently discontinued dialysis (excluding those reported in fields 08A, 09A, 10A and 11A) who had been dialyzing in-unit during the survey period.

Field 12B: Home--Discontinued Dialysis. Enter the number of chronic patients who permanently discontinued dialysis (excluding those reported in fields 08B, 09B, 10B, and 11B) who had been dialyzing at home during the survey period.

Lost to Follow-Up:

Field 13A: In-Unit--Lost to Follow-Up (LTFU). Enter the number of patients who had been dialyzing in-unit who left your dialysis program during the survey period and whose current status is unknown to your facility (lost to follow-up). Do not include those reported in fields 08A, 09A, 10A, 11A, or 12A.

Field 13B: Home--Lost to Follow-Up (LTFU). Enter the number of patients, followed by your facility, who had been dialyzing at home who were removed from your facility's rolls during the survey period, and whose current status is unknown to your facility (lost to follow-up). Do not include those reported in fields 08B, 09B, 10B, 11B, or 12B.

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Patients Receiving Care at the End of the Survey Period

NOTE: DO NOT COUNT A PATIENT IN MORE THAN ONE FIELD. Patients receiving care at the beginning of the survey period plus the additions during the survey period minus the losses during the survey period should equal the patients receiving care (remaining) at the end of the survey period. In terms of the survey form, this means that field 03 plus fields 04A through 07B minus fields 08A through 13B equals field 28.

Staff-Assisted Dialysis:

Field 14: Hemodialysis: Enter the number of patients who, at the end of the survey period, were receiving staff-assisted hemodialysis.

Field 15: Peritoneal Dialysis. Enter the number of patients who, at the end of the survey period, were receiving staff-assisted peritoneal dialysis.

In-Unit Self-Dialysis:

Field 16: Hemodialysis. Enter the number of in-unit self-hemodialysis patients as of the end of the survey period. Self-dialysis training patients are to be reported in field 18.

Field 17: Peritoneal Dialysis. Enter the number of in-unit self-peritoneal dialysis patients as of the end of the survey period. Self-dialysis training patients are to be reported in field 19.

Self-Dialysis Training:

Field 18: Hemodialysis. Enter the number of patients who are in a self-hemodialysis training program as of the end of the survey period. Patients are to be reported in this category only if the training is designed to enable them to perform their own self-dialysis in-unit or at home.

Field 19: Peritoneal Dialysis. Enter the number of patients who are in a self-peritoneal dialysis training program as of the end of the survey period. Patients are to be reported in this category only if the training is designed to enable them to perform their own self-dialysis in-unit or at home.

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Field 20: Continuous Ambulatory Peritoneal Dialysis (CAPD) Enter the number of patients who are in a CAPD training program as of the end of the survey period. Patients are to be reported in this category only if the training is designed to enable them to independently perform CAPD.

Field 21: Continuous Cycling Peritoneal Dialysis (CCPD) Enter the number of patients who are in a CCPD training pprogram as of the end of the survey period. Patients are to be reported in this category only if the training is designed to enable them to independently perform CCPD.

Field 22: Total In-Unit Enter the total number of patients who are in-unit status as of the end of the survey period (the sum of fields 14 through 21).

Home Dialysis

Field 23: Hemodialysis. Enter the number of patients who hemodialyze at home as of the end of the survey period.

Field 24: Peritoneal Dialysis. Enter the number of patients who are on home peritoneal dialysis as of the end of the survey period.

Field 25: Continuous Ambulatory Peritoneal Dialysis (CAPD). Enter the number of patients who are on CAPD as of the end of the survey period.

Field 26: Continuous Cycling Peritoneal Dialysis (CCPD) Enter the number of patients who are on CCPD as of the end of the survey period.

Field 27: Total Home: Enter the total number of patients who are home status as of the end of the survey period (the sum of fields 23 through 26).

Total:

Field 28: Total. Enter the total number of patients on your facility's register at the end of the survey period (the sum of fields 22 and 27).

Patient Eligibility Status--End of Survey Period

NOTE: Fields 29 + 30 + 31 should equal the total number of patients at the facility at the end of the survey period (this should be the same number as that in field 28).

Field 29: Currently Enrolled in Medicare. Enter the number of patients at the end of the survey period who were enrolled in Medicare.

Field 30: Medicare Application Pending. Enter the number of patients at the end of the survey period who had Medicare applications pending.

Field 31: Non-Medicare. Enter the number of patients at the end of the survey period who were not enrolled in Medicare and who did not have Medicare applications pending.

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Home/Self-Dialysis Patients Completing Training

NOTE: The following section (fields 32 through 37) should be completed only by those facilities that have self-care training programs. Included in this section will be the number of patients who, during the survey period, successfully completed a course of self-dialysis training at the reporting facility which enabled them to self-dialyze in-unit or at home. Patients who were still in a self-dialysis training course on the last day of the survey period are not to be counted in these fields; that data is to be reported in fields 18 through 21. Unsuccessful trainees (those who did not go home or initiate self-care in a facility) are not to be counted here. (This count is a non-add, non-subtract count for caseload purposes.)

Hemodialysis

Field 32: Home Hemodialysis. Enter the number of patients who, during the survey period, successfully completed a course of self-dialysis training for home self-hemodialysis.

Field 33: In-Unit Self-Hemodialysis. Enter the number of patients who, during the survey period, successfully completed a course of self-dialysis training for in-unit self-hemodialysis.

Peritoneal Dialysis

Field 34: Home Peritoneal Dialysis. Enter the number of patients who, during the survey period, successfully completed a course of self-dialysis training for home self-peritoneal dialysis.

Field 35: In-Unit Self Peritoneal Dialysis. Enter the number of patients who, during the survey period, successfully completed a course of self-dialysis training for in-unit self-peritoneal dialysis.

Continuous Ambulatory Peritoneal Dialysis

Field 36: CAPD. Enter the number of patients who, during the survey period, successfully completed a course of self-dialysis training for continuous ambulatory peritoneal dialysis.

Continuous Cycling Peritoneal Dialysis

Field 37: CCPD Enter the number of patients who, during the survey period, successfully completed a course of self-dialysis training for continuous cyclying peritoneal dialysis.

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Transient Patients

Field 38: Transient Patients Treated During Survey Period. Enter the number of transient chronic patients who received care at your facility during the survey period. For purposes of this survey, a transient patient is one who does not intend to utilize the reporting facility for ongoing maintenance therapy. This field is a count of patients, not episodes of treatment. Therefore, if a patient is treated at a facility in February and again at that same facility in March, he/she is counted only once.

Field 39: Transient Patients—Number of Treatments During Survey Period. Using the definition of "transient patient" given above, enter the number of transient patient dialysis treatments (all dialysis settings) given during the survey period.

TREATMENT LOAD

NOTE: The following section (fields 40 through 49) should reflect only treatments given to ESRD patients. Self-care training treatments should be reported only in fields 46 through 49. All such treatments, including those provided to transients, should be reported in fields 40 through 49, where appropriate.

Hemodialysis

Field 40: Inpatient Hemodialysis. Enter the number of inpatient hemodialysis treatments given to chronic dialysis patients and to patients pre-and post-transplant during the survey period. Self-care training treatments should not be included here. Also, in some unusual situations, a dialysis facility may, by written arrangement, provide the staff and/or equipment to perform inpatient treatments for chronic patients in hospitals. These treatments should only be reported by one of the facilities.

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Field 41: Staff-Assisted Outpatient Treatments. Enter the number of in-unit staff-assisted hemodialysis treatments provided on an outpatient basis during the survey period.

Field 42: In-Unit Self-Care Outpatient Treatments. Enter the number of outpatient hemodialysis treatments performed by in-unit self-dialyzing patients during the survey period.

Peritoneal Dialysis

Field 43: Inpatient Peritoneal Dialysis. Enter the number of inpatient peritoneal dialysis treatments provided to chronic dialysis patients and to patients pre- and post-transplant during the survey period. Self-care training peritoneal treatments should not be included here. Also, in some unusual situations, a dialysis facility may, by written arrangement, provide the staff and/or equipment to perform inpatient treatments for chronic patients in hospitals. These treatments should only be reported by one of the facilities.

Field 44: Staff-Assisted Outpatient Treatments. Enter the number of in-unit staff-assisted peritoneal treatments provided on an outpatient basis during the survey period.

Field 45: In-Unit Self-Care Outpatient Treatments. Enter the number of outpatient peritoneal dialysis treatments performed by in-unit self-dialyzing patients during the survey period.

Self-Care Training Treatments

NOTE: These treatment counts should not be included in prior fields 40 through 45.

Field 46: Hemodialysis. Enter the number of hemodialysis training treatments given during the survey period.

Field 47: Peritoneal Dialysis. Enter the number of peritoneal dialysis training treatments given during the survey period.

Field 48: CAPD. Enter the number of CAPD training treatments given during the survey period.

Field 49: CCPD Enter the number of CCPD training treatments given during the survey period.

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Signatures

Part One of the Facility Survey requires signatures, as follows:

Completed by:

Enter the date completed and the name, title, and telephone number of the person who completed the Facility Survey for your facility. This person should be the individual who the ESRD network of HCFA can contact to discuss any information provided in the Facility Survey.

Verified by:

Enter the date verified and the signature and title of the facility's renal administrator.

PART TWO

(FOR COMPLETION BY TRANSPLANT FACILITIES ONLY)

I. PATIENTS/TRANSPLANTS

Field 50: Patients Who Received Transplant at This Facility. Enter the number of patients who received a kidney transplant at your facility during the survey period. If a patient received more than one transplant at your center during the survey period the patient is to be counted only once. (The figure in field 50 should equal the sum of fields 51 + 52 + 53.)

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Patient Eligibility Status/of Patients Transplanted During Survey Period. Fields 51-53 refer to those patients actually transplanted during the survey period. The total of fields 51 through 53 equals the same number reported in field 50.

Field 51: Currently Enrolled In Medicare. Enter the number of patients transplanted during the survey period who were enrolled in Medicare.

Field 52: Medicare Application Pending. Enter the number of patients transplanted during the survey period who had Medicare applications pending.

Field 53: Non-Medicare. Enter the number of patients transplanted during the survey period who were not enrolled in Medicare and did not have Medicare applications pending.

Transplants Performed at This Facility:

Field 54: Transplants Performed at This Facility--Living Donor. Enter the number of live donor kidney transplants performed at your center during the survey period.

Field 55: Transplants Performed at This Facility--Cadaveric Donor. Enter the number of cadaveric donor kidney transplants performed at your center during the survey period.

Field 56: Transplants Performed at This Facility--Total Fields 54 Through 55. Enter the sum of fields 54 and 55.

Patients Awaiting Transplant:

Field 57: Patients Awaiting Transplant--Dialysis. Enter the number of current dialysis patients actively awaiting transplant at your center as of the last day of the survey period. These patients must (a) be medically able, (b) have given consent, and (c) be on an active transplant list. This count is limited to individuals awaiting transplant at the reporting center.

Field 58: Patients Awaiting Transplant--Non-Dialysis.
Following the procedures described above, enter the number of non-dialysis patients who are awaiting transplant as of the last day of the survey period. This is to include patients scheduled for transplant who have not yet initiated a regular course of dialysis.

II. CADAVER KIDNEYS

Enter the numbers of cadaver kidneys acquired by your center during the survey period in the appropriate blocks according to their source and disposition. Actual, rather than potential, acquisition is assumed.

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Harvested at This Center:

Determine the number of cadaveric kidneys that were harvested at your center during the survey period that were:

Field 59: Transplanted at this center

Field 60: Sent to another center for transplantation

Field 61: Not used (discarded)

Field 62: Total of fields 59 through 61.

Cadaveric kidneys procured outside your center by a procurement team from your center are not to be included in these categories.

Obtained from Another Transplant Center/Organ Procurement Agency:

Determine the number of cadaveric kidneys that were harvested outside your center either at another approved transplant center or through an OPA that were:

Field 63: Transplanted at your center

Field 64: Sent to another center

Field 65: Not used (discarded)

Field 66: Total of fields 63 through 65.

Obtained from a Non-Transplant Hospital:

Determine the number of cadaveric kidneys that were harvested outside your center in a hospital not approved by Medicare as a transplant center that were:

Field 67: Transplanted at your center

Field 68: Sent to another center

Field 69: Not used (discarded)

Field 70: Total of fields 67 through 69.

These counts should include, where applicable, any kidneys harvested outside your center by a procurement team from your center.

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Disposition of Cadaver Kidneys:

Cadaver Kidneys Transplanted at This Facility:

Field 71: Should equal the total of fields 59 + 63 + 67. This should be the same number that appears in Field 55. In situations where two kidneys from one cadaveric donor are transplanted to one patient, the total in field 71 can be greater than field 55. When this situation occurs, it should be annotated in Part Three (Remarks).

Cadaveric Kidneys Sent to Another Facility:

Field 72: Should equal the total of fields 60 + 64 + 68.

Cadaveric Kidneys Not Used

Field 73: Should equal the total of fields 61 + 65 + 69.

Signatures

Part Two of the Facility Survey requires signatures, as follows:

Completed by:

Enter the date completed and the name, title, and telephone number of the person who completed the Facility Survey for your facility. This person should be the individual who the ESRD network of HCFA can contact.

Verified by:

Enter the date verified and the signature and title of the facility's renal administrator.

PART THREE

You may include here any remarks or additional information you wish to supply concerning the information furnished on this survey.

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ESRD Transplant Information, HCFA-2745-U3

This form is completed by the transplant provider within 2 weeks following the date of transplant.

Mail the original (PINK) copy and the Information Copy (YELLOW) to the Network office. The Network will forward the pink copy to the ESRD Support Section and will retain the yellow copy for its files.

The Facility Copy (WHITE) is to be retained by the provider.

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ESRD Transplant Information
End-Stage Renal Disease Medical Information System

Form Approved OMB No. 0938-0084

Transplant Recipient

1 Name (Last, First, Middle Initial)

2 Date of Birth (Month, Day, Year)

3 Health Insurance Claim Number (if non-Medicare, social security number)

4a Sex
1 ☐ Male
2 ☐ Female

4b If Female, enter number of pregnancies

5a Race
1 ☐ American Indian or Alaskan Native
2 ☐ Asian or Pacific Islander
3 ☐ Black
4 ☐ White
5 ☐ Unknown

5b Ethnicity
1 ☐ Hispanic origin
2 ☐ Not of Hispanic origin

6a Date of Transplant (Month, Day, Year)

6b Transplant Number
1 ☐ 1st
2 ☐ 2nd
3 ☐ 3rd
4 ☐ 4th or more

6c If 2, 3, or 4 Date preceding graft failed (mo., yr.)
1
2
3

7 Transplant Hospital Provider Number

8 Transplant Surgeon's Name, City, State, Zip Code

9 Blood Group 1 ☐ O 2 ☐ A 3 ☐ B 4 ☐ AB

10 PRA (Percent Reactive Antibody)
Highest
At time of transplant

11a
1 MLC a ☐ 1 way b ☐ 2 way ☐ not done
2 Stim. Index a ☐☐☐ 1 way b ☐☐☐ 2 way
3 Relative Response a ☐☐☐ 1 way b ☐☐☐ 2 way

11b HLA Haplotyped 1 ☐ yes 2 ☐ No

Locus A		
Locus B		
Locus C		
Locus DR		
Locus MB		

12a Nephrectomy
1 ☐ one
2 ☐ two
3 ☐ no

12b If yes, enter date (Month, Day, Year)

13 Reason for Nephrectomy
1 ☐ Uncontrolled hypertension
2 ☐ Infection
3 ☐ Reflux
4 ☐ Routine preparation for transplant
5 ☐ Other, specify

14a Splenectomy 1 ☐ Yes 2 ☐ No

14b If yes, enter date (Month, Day, Year)

15 HBsAg Status
1 Positive Ever a ☐ Yes b ☐ No c ☐ unknown
2 Positive Now a ☐ Yes b ☐ No c ☐ unknown
3 Antibody to HBsAg a ☐ Yes b ☐ No c ☐ unknown

16 CMV Status, Antibody Present
1 ☐ Yes 2 ☐ No 3 ☐ unknown

17a Pre-Transplant Blood Transfusions
1 ☐ Yes 2 ☐ No If yes, number of transfusions

17b Check block if frozen blood only was used for pre-transplant transfusions ☐

17c Date of Last [redacted] Blood Transfusion (Month, Day, Year)

18 Transfusions at time of transplant
1 ☐ Yes
2 ☐ No

19 Creatinine Decline Without Dialysis at 1 week Post-Transplant
1 ☐ Yes 2 ☐ No 3 ☐ Unknown

Transplant Donor

20a Donor
1 ☐ Cadaveric
2 ☐ Living Related

20b If Cadaveric
a ☐ Local b ☐ Related

20c If Living Related
1 ☐ HLA identical
2 ☐ Haplo identical
3 ☐ Haplo dissimilar
4 ☐ Identical twin

21 Sex
1 ☐ Male 2 ☐ Female

22 Age (Years)

23 Blood Group
1 ☐ O 2 ☐ A 3 ☐ B 4 ☐ AB

24a Race
1 ☐ American Indian or Alaskan Native
2 ☐ Asian or Pacific Islander
3 ☐ Black
4 ☐ White
5 ☐ Unknown

24b Ethnicity
1 ☐ Hispanic origin 2 ☐ Not of Hispanic origin

Completed by _____ (signature)

Title _____

Date _____

25 Infections at Time of Harvest
1 HBsAg Positive a ☐ Yes b ☐ No c ☐ unknown
2 CMV Antibody a ☐ Yes b ☐ No c ☐ unknown
3 Other, specify a ☐ Yes b ☐ No c ☐ unknown

26 Cancer at Time of Harvest
1 ☐ Intracranial
2 ☐ Extracranial
3 ☐ None

27 HLA HAPLOTYPED ☐ YES ☐ NO

Locus A		
Locus B		
Locus C		
Locus DR		
Locus MB		

28 Most Recent Renal Function Chemistries at Donor Nephrectomy
BUN Serum Creatinine

29 Warm Ischemia Time (Minutes)

30 Cold Time (Hours Minutes)

31 Pulsatile Perfusion Total Time (Hours Minutes)

32a Donor Pretreatment
1 ☐ Steroids
2 ☐ Diuretics a ☐ Mannitol b ☐ Lasix
3 ☐ Cyclophosphamide
4 ☐ Methylprednisolone and cyclophosphamide
5 ☐ Heparin
6 ☐ Other, specify

32b If 3, 4, or 5 above
1 ☐ 0-5 hours prior to harvest
2 ☐ 5 or more hours prior to harvest

This report is required by law (42 U.S.C. 426; 20 CFR 405, Section 2133); individually identifiable patient information will not be disclosed except as provided for by the Privacy Act of 1974 (5 U.S.C. 552a; 45 CFR Part 5a).

Form HCFA 2745-U3 (10-81) Destroy Prior Editions

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Department of Health and Human Services
Health Care Financing Administration

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INSTRUCTIONS FOR COMPLETING THE ESRD TRANSPLANT INFORMATION, HCFA-2745-03

ITEM	PROCEDURE
1	Name (Last, First, Middle Initial) Enter the transplant recipient's name (last, first, middle initial). Bold lines separate the last name from the first name, and the first name from the middle initial.
2	Date of Birth (Month, Day, Year) Enter the transplant recipient's date of birth (month, day, year). Month and day are expressed in 2 digits; e.g., January is 01, November is 11; the first of the month is 01, the fifteenth is 15. The year is expressed by entering the last two digits of the year; e.g., 84 for 1984.
3	Health Insurance Claim Number Enter the transplant recipient's health insurance claim number. If unable to determine the health insurance claim number, enter the 9-digit social security number.
4a	Sex Check the box which indicates the sex of the transplant recipient.
4b	If Female, Enter Number of Pregnancies For the purposes of this form, pregnancy is defined to be synonymous with diagnosed conception. If it was determined that a woman was pregnant and a subsequent abortion occurs, that is to be counted as one pregnancy. As an example, a situation where a woman had a spontaneous abortion and two full-term children would be coded as three pregnancies.
5a	Race Check the box which describes the race of the transplant recipient. If unknown, check the apropriate box. Definitions of the basic racial

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categories for Federal statistics are as follows:

American Indian or Alaskan Native: A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

Asian or Pacific Islander: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, and Philippine Islands and Samoa.

Black: A person having origins in any of the black racial groups of Africa.

White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

5b Ethnicity

Check the box which describes the ethnicity of the transplant recipient as described below:

Hispanic Origin: A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

Not of Hispanic Origin: A person of culture or origin not described above, regardless of race.

6a Date of Transplant (Month, Day, Year)

Enter the date the kidney transplant occurred using the day on which circulation was restored to the transplanted kidney. Code the date as explained for item 2.

6b Transplant Number

Transplant number is defined as the number of

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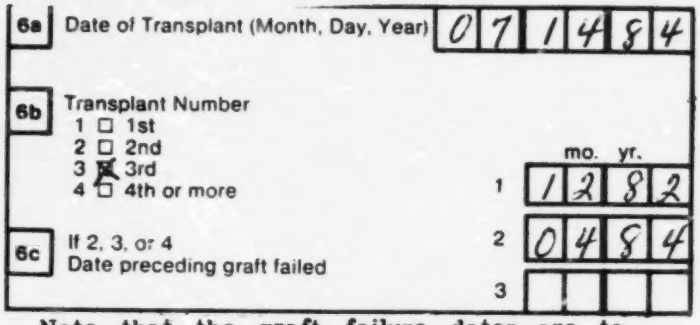
transplants this particular patient has received, including the present transplant. If the recipient has had two previous transplants and this is the third, the box labeled "3rd" must be checked. If this is the recipient's first transplant, the box labeled "1st" must be checked.

6c

If 2, 3, or 4 - Date Preceding Graft Failed

If the recipient is receiving transplant number 2, 3, or 4, (as indicated in item 6b), enter the date the preceding graft(s) failed. The example below shows how to record failure dates for a person who has received his/her third transplant (i.e., two previous transplants have failed):


6a Date of Transplant (Month, Day, Year) 0 7 1 4 8 4
6b Transplant Number
1 ☐ 1st
2 ☐ 2nd
3 ☒ 3rd
4 ☐ 4th or more
mo. yr.
1 1 2 8 2
6c If 2, 3, or 4 Date preceding graft failed
2 0 4 8 4
3

Note that the graft failure dates are to include only the month and year (not the day) and are to be coded as explained for item 2.

7

Transplant Hospital Provider Number

Enter here the 6-digit renal provider number of the hospital where the transplant was performed.

8

Transplant Surgeon's Name, City, State, Zip Code

Enter the name and office address of the surgeon who performed the renal transplant.

9

Blood Group

Blood group means the appropriate ABO system blood group to which the transplant recipient belongs. Check the box which is appropriate.

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10 **PRA (Percent Reactive Antibody)**

Percent reactive antibody is the percentage of individuals in a cell panel against which the recipient possesses cytotoxic antibodies. The top space is for the highest PRA prior to transplant and the bottom space is for the PRA at the time of transplant. The actual value of the PRA must be entered. This percent must be entered as a whole number; if necessary, round to the nearest whole number (e.g., 99.6 = 100). A fraction is not acceptable--it must appear as a percentage. If the PRA is unknown, indicate that in the applicable box. If the response is negative, enter zero (0). (Do not enter B cell data.)

11a **MLC (Mixed Lymphocyte Culture)**

The 2-way MLC is performed using untreated cell populations of donor and recipient, while the 1-way test is performed using donor cells which have been treated or irradiated to suppress transformation of the lymphocytes. Complete 1, 2, and 3 according to which method your institution uses (i.e., (a) for 1-way MLC, (b) for 2-way MLC).

1 MLC Indicate whether MLC was performed 1-way or 2-way. If MLC not done, check the box "not done."

2 Stim. Index Indicate the results in the appropriate box for 1-way or 2-way.

3 Relative Response Indicate the results in the appropriate box for 1-way or 2-way.

11b **HLA Haplotyped** ☐ Yes ☐ No

HLA (human leucocyte antigen) refers to the antigens identified from tissue typing the recipient which will be compared to determine the number of antigens common to both donor and recipient. Indicate in the appropriate box whether or not the recipient was haplotyped.

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If an antigen was detected, leave a dash (—). If typing not done, leave blank. Only one number per square may be entered next to the loci. Entries of zero (0) alone are not acceptable.

12a Nephrectomy

If the transplant recipient underwent a nephrectomy of his/her native kidneys, indicate in the appropriate box the number (one or two) of kidneys removed. If a nephrectomy had been performed earlier and one kidney removed, and a second nephrectomy is performed and the other native kidney removed, report the date of the second nephrectomy and mark the box labeled "two" to indicate that both native kidneys have been removed. If a nephrectomy was not performed, indicate this by checking the box labeled "no."

12b Date (Month, Day, Year)

If a nephrectomy was performed, enter the date performed (month, day, year) as explained for item 2.

13 Reason(s) for Nephrectomy

If a nephrectomy was performed, check the reason(s) which applies. If the reason is "Other," please specify.

14a Splenectomy

Check the box which indicates whether or not the transplant recipient underwent a splenectomy.

14b Date (Month, Day, Year)

If the splenectomy was performed, enter the date it was performed (month, day, year) as explained for item 2.

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15 HBsAG Status

Indicate in the appropriate box whether or not the transplant recipient had a positive hepatitis B_S antigen. If unknown, check that box. Indicate in the appropriate box whether or not the transplant recipient now has a positive hepatitis B_S antigen. If unknown, check that box. If your facility determines antibody to hepatitis B_S antigen, complete this portion of item 15. Bear in mind that if the antibody is present, it indicates that sometime in the past, the antigen was present. Therefore, "yes" should be checked in "Positive Ever."

16 CMV (Cytomegalovirus) Status

Indicate whether or not CMV antibody is present, not present, or unknown.

17a Pre-Transplant Blood Transfusions

A pre-transplant blood transfusion is one administered up to 10 days prior to the transplant. Indicate here whether or not the transplant recipient received any pre-transplant blood transfusions. As an example, 15 transfusions would be entered 0 1 5.

17b Frozen Blood

Check this box if the patient received frozen blood only in pre-transplant blood transfusions.

17c Date of Last Blood Transfusion

Enter the date (month, day, year) of the last pre-transplant blood transfusion.

18 Transfusions at Time of Transplant

Indicate whether or not blood transfusions were given in the operating room at the time of transplant surgery.

19 Creatinine Decline Without Dialysis at 1 Week Post Transplant

Indicate in this item whether or not there was creatinine decline greater than 3 milligrams per decilitre without dialysis at 1 week post-transplant. If more than one creatinine is done during the first week post-transplant, enter the most recent. If unknown, please indicate.

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20a

Donor

Indicate here whether the kidney donor was cadaveric or living related.

20b

If Cadaveric . . .

If cadaveric, and the donor kidney was removed at the transplant center where the transplant was performed, check the box labeled "local." If cadaveric, and the donor kidney was removed at an institution other than the one where the transplant was performed, check the box labeled "shared."

20c

If Living Related . . .

If the donor was living related, check the appropriate box for two haplotype match (HLA identical), one haplotype match (Haplo identical), no haplotype match (Haplo dissimilar), or identical twin. Only one box may be checked.

21

Sex

Check the box indicating the sex of the donor.

22

Age (Years)

Enter the age (years) of the donor; e.g., age 5 years would be entered [0][5] ; age 23 years would be [2][3].

23

Blood Group

Check the appropriate box for the blood group of the donor, as explained for item 9.

24

Race

Check the box which describes the race of the donor, as explained for item 5.

25

Infections at Time of Harvest

For donor, indicate whether or not hepatitis B_S antigen was positive (or unknown); whether or not CMV antibody was present (or presence unknown). If other infections were present in the donor at the time of harvest, specify what they were (see below). If the information is unknown, check that box. If there were none, write the word "none."

If other infections were present in the donor, enter the numerical code, as shown below, on the line following the word "specify."

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Code	Infection
1	Positive Sputum Culture—Gram Negative Bacteria
2	Positive Urine Culture—Greater than 10,000 per ml.
3	Positive Urine Culture—Greater than 100,000 per ml.
4	Pneumonia—Gram Positive
5	Pneumonia—Gram Negative
6	Meningitis
7	Bacteremia During Admission
8	All Others

26 Cancer at Time of Harvest

If cancer was present in the donor at time of harvest, check the box indicating whether it was intracranial or extracranial. If cancer was not present, indicate that in the appropriate box.

27 HLA Haplotyped ☐ Yes ☐ No

In the space to the right of the term "HLA", the transplant center must indicate whether or not the donor was haplotyped (as done in item 11b for the recipient). The words "Haplotyped Yes" or "Haplotyped No" are sufficient. Complete the loci data as explained for item 11b.

28 Renal Function Chemistries at Donor Nephrectomy

Indicate the most recent donor Blood Urea Nitrogen (BUN) and serum creatinine prior to harvest. Round the BUN figure to the nearest whole number.

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29 Warm Ischemia Time (Minutes)

Three boxes are available for entering warm ischemia time. Warm ischemia time begins when the blood ceases to flow through the kidney in the living or cadaveric donor. In heart-beating cadavers, this occurs when the renal artery (or aorta) is clamped. Warm ischemia time ends when the flush procedure begins. The time, in minutes, must be entered; e.g., 7 minutes would be shown [0|0|7]. If unknown or not applicable, leave blank.

30 Cold Time (Hours, Minutes)

Enter the length of time the living or cadaveric donor kidney was preserved on ice. The first two boxes are for hours; the second two are for minutes; e.g., 1 hour and 25 minutes would be shown as [0|1] [2|5]; 1 hour would be shown as [0|1] [0|0]; 45 minutes would be shown as [0|0] [4|5]. If unknown or not applicable, leave blank.

31 Pulsatile Perfusion Total Time (Hours, Minutes)

Enter the cadaveric donor kidney preservation time on pulsatile perfusion. The first two boxes are for hours; the second two are for minutes. See examples shown for item 30.

32a Donor Pretreatment

Check the type of donor pretreatment medication administered. If either Mannitol or Lasix are checked, box 2 "Diuretics" must also be checked. Do not check box 4 unless both these drugs were administered.

32b If 3, 4, or 5 above . . .

Check the box indicating the time prior to harvest the donor received any of the medications described in items 3, 4, or 5 of item 32a.

Signature

The signature of the individual completing the form must appear in the space provided in the lower left-hand portion of the form. Include the person's title, telephone number, and the date the form was completed.

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ESRD Transplant Follow-up Form

The transplant center completes the ESRD Transplant Follow-up form at the time the transplant recipient is discharged from the hospital following the transplant surgery, again at 6 months post-transplant, again at 1 year post-transplant, and yearly thereafter (unless the patient dies, the transplanted kidney fails, or the patient is lost-to-follow-up.)

A supply of Transplant Follow-up forms is available at each transplant center for use in completing the form initially, i.e., at the time the patient is discharged following the transplant surgery. The subsequent Transplant Follow-ups are generated by the Network offices at the intervals mentioned above. These subsequent Transplant Follow-ups are to be completed by the transplant center unless the patient is followed by a physician other than the transplant surgeon. In such a case, the attending physician at the time the Transplant Follow-up is due to be completed is responsible for completing the form.

Mail the completed Transplant Follow-up form to the Network.

NOTE: The tranpslant center is responsible for notifying the Network office of a change in the follow-up physician. That Network (i.e., the Network in which the transplant was performed) is responsible for ensuring that the Follow-up gets to the appropriate physician for completion, even in situations that cross Network boundaries.

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ESRD CONFIDENTIAL - TO BE RELEASED TO AUTHORIZED PERSONNEL ONLY

REPORT DATE
(1)
NETWORK

NATIONAL INSTITUTES OF HEALTH
END-STAGE RENAL DISEASE PROGRAM MANAGEMENT AND MEDICAL INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HUMAN SERVICES

TRANSPLANT FOLLOW-UP

(2) TRANSPLANT SURGEON OR PHYSICIAN RESPONSIBLE FOR FOLLOW-UP DATA

(3) PROVIDER NUMBER

(4) PATIENT NAME LAST

FIRST

(5) I

(6)

(7) MEDICARE HIC NUMBER

(8) DATE OF TRANSPLANT

(9) TRANSPLANT FOLLOW-UP PERIOD:_____

----------PATIENT STATUS----------

	YES	NO
(10) IS PATIENT LIVING AT TIME OF THIS FOLLOW-UP?	( )	( )

(11) IF NOT LIVING, GIVE DATE OF DEATH:
(MO)_ _ (DAY)_ _ (YEAR)_ _

(12) IS PATIENT LOST TO FOLLOW-UP AT TIME OF THIS FOLLOW-UP?	( )	( )

(13) IF LOST TO FOLLOW-UP GIVE DATE LAST SEEN:
(MO)_ _ (DAY)_ _ (YEAR)_ _

(14) IF PATIENT IS LIVING, ENTER REHABILITATION CODE FROM TABLE A, ATTACHED: _ _

(15) WAS THE PATIENT TRANSFERRED TO ANOTHER PHYSICIAN OR DIALYSIS FACILITY?	( )	( )

(A) PHYSICIAN NAME _____
_____
(B) PROVIDER NUMBER _____
(C) DATE TRANSFERRED:
(MO)_ _ (DAY)_ _ (YEAR)_ _

----------GRAFT STATUS----------

	YES	NO
(16) WAS DIALYSIS PERFORMED DURING THIS FOLLOW-UP PERIOD?	( )	( )
(17) DID GRAFT FAIL DURING THIS FOLLOW-UP PERIOD?	( )	( )

(18) IF YES, GIVE DATE OF FAILURE:
(MO)_ _ (DAY)_ _ (YEAR)_ _

(19) DATE OF GRAFT FAILURE WAS DETERMINED BY:

(A) PATIENT RECEIVING AN ADDITIONAL TRANSPLANT	( )	( )
(B) PATIENT RETURNING TO REGULAR COURSE OF DIALYSIS	( )	( )
(C) OTHER	( )	( )

(20) IF GRAFT FAILED, ENTER CAUSE OF TRANSPLANT FAILURE CODE FROM TABLE B, ATTACHED:

(A) PRIMARY: _ _ _

(B) SECONDARY: _ _ _

(21) WAS GRAFT REMOVED DURING THIS FOLLOW-UP PERIOD?	( )	( )

(22) IF YES, GIVE DATE OF REMOVAL:
(MO)_ _ (DAY)_ _ (YEAR)_ _

----------OTHER----------

	YES	NO
(23) IMMUNOSUPPRESSIVE THERAPY DURING THIS FOLLOW-UP PERIOD:		
(A) IMURAN (AZATHIOPRINE)	( )	( )
(B) CYTOXAN	( )	( )
(C) PREDNISONE	( )	( )
(D) ANTITHYMOCYTE GLOBULIN	( )	( )
(E) IRRADIATION	( )	( )
(F) SOLUMEDROL	( )	( )
(G) CYCLOSPORIN A	( )	( )
(H) OTHER:		

SPECIFY:_____
_____

(24) WERE THERE EPISODES OF CLINICAL REJECTION DURING THIS FOLLOW-UP PERIOD?	( )	( )

(25) SERUM CREATININE:

(A) MAXIMUM READING DURING THIS FOLLOW-UP PERIOD: _ _._

(B) MOST RECENT READING DURING THIS FOLLOW-UP PERIOD: _ _._

(26) REMARKS:

COMPLETED BY:_____

DATE:_____

THIS FORM CONFORMS WITH CRITERIA IN 5 CFR 1320.7 (K) (1).

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TABLE A

REHABILITATION CODES

CODE	DESCRIPTION
1	COMPLETE PHYSICAL AND/OR MENTAL DISABILITY: PATIENT HOSPITALIZED OR ESSENTIALLY BEDRIDDEN AT HOME
2	PATIENT UNABLE TO WORK OR ATTEND SCHOOL
3	PATIENT WORKS OR ATTENDS SCHOOL PART-TIME (LESS THAN 50%)
4	PATIENT WORKS OR ATTENDS SCHOOL PART-TIME (GREATER THAN 50%)
5	PATIENT WORKS OR ATTENDS SCHOOL FULL-TIME BUT AT A LOWER LEVEL OF PERFORMANCE THAN AT PRE-ILLNESS
6	PATIENT WORKS OR ATTENDS SCHOOL FULL-TIME AT PRE-ILLNESS LEVEL OF PERFORMANCE
7	PATIENT IS PHYSICALLY AND MENTALLY ABLE TO WORK OR ATTEND SCHOOL BUT HAS CHOSEN NOT TO
8	PATIENT IS PHYSICALLY AND MENTALLY ABLE TO WORK BUT UNABLE TO FIND WORK
9	UNKNOWN

NOTE: THE TERM "WORK" INCLUDES HOUSEWORK.

TABLE B

CAUSE OF TRANSPLANT FAILURE CODES

CODE	CAUSE
01	ACUTE REJECTION
02	CHRONIC REJECTION
03	HYPERACUTE REJECTION (BIOPSY-PROVED)
04	ACCELERATED HUMORAL REJECTION
05	PRIMARY NON-FUNCTION
06	RECURRENCE OF ORIGINAL DISEASE (BIOPSY-PROVED)
07	PAPILLARY NECROSIS
08	PARENCHYMAL ABSCESS
09	PARENCHYMAL HEMORRHAGE
10	LOCAL WOUND INFECTION
11	ARTERIAL HEMORRHAGE
12	VENOUS HEMORRHAGE
13	RENAL VEIN THROMBOSIS
14	RENAL ARTERY THROMBOSIS
15	RENAL ARTERY STENOSIS
16	INADEQUATE GRAFT VASCULATURE
17	BLADDER LEAK
18	URETERAL LEAK
19	URETERAL OBSTRUCTION
20	RENAL PELVIC OR CORTICAL LEAK
21(A-G)	STABLE RENAL FUNCTION BUT WITHDRAWAL OF MAINTENANCE IMMUNOSUPPRESSION BECAUSE OF:
	21A INFECTION
	21B GASTRO-INTESTINAL HEMORRHAGE
	21C VISCERAL PERFORATION
	21D MALIGNANCY
	21E SKELETAL COMPLICATIONS
	21F STEROID PSYCHOSIS
	21G OTHER, SPECIFY: _____
22	POOR PATIENT COMPLIANCE WITH MAINTENANCE IMMUNOSUPPRESSION
23	OTHER

ESRD Program Management and
Medical Information System

INSTRUCTIONS FOR COMPLETION OF TRANSPLANT FOLLOW-UP FORM

The Transplant Follow-up form is to be completed initially by the transplant surgeon for each end-stage renal disease (ESRD) patient for whom he/she has performed a renal transplant. Subsequent Follow-up forms are to be completed by the transplant surgeon or other physician (attending physician) knowledgeable of the information requested on the Follow-up form.

Each renal transplant center should have on hand a supply of Transplant Follow-up forms. (These forms can be obtained by calling the local ESRD Network Coordinating Council (NCC) or the Health Care Financing Administration (HCFA)). This supply of forms will facilitate completion of the first, or initial, Transplant Follow-up, which must be done at the time the transplant recipient, or patient, is discharged from the hospital following the transplant surgery, or at the time the patient dies, if this occurs during the hospital stay.

Each transplant surgeon or other physician (as described in the first paragraph) will receive subsequent Follow-up forms in the mail for specific patients at the times the Follow-ups are due. These forms are to be completed by the transplant surgeon or attending physician and then returned to the NCC.

After the transplant surgeon completes the Follow-up form for the first time (i.e., when the patient is discharged from the hospital or at the time the patient dies, if this occurs during the hospital stay), he/she (or the transplant coordinator) must sign and date the form, and forward it to the NCC to which the transplant center belongs. The Follow-up form should be received by the NCC within 2 weeks of the patient's date of discharge from the hospital or date of death, if the patient died during the hospital stay.

The subsequent Transplant Follow-up forms, as stated above, will be sent to the transplant surgeon or other physician by the NCC. These should be completed, signed, dated, and returned to the NCC within 2 weeks after they are received by the transplant surgeon or other physician.

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Once the completed Transplant Follow-up is received in the NCC, the NCC will review the form to ensure the accuracy of the information, will add that information to its data base, and will then send the form to the ESRD Support Section for inclusion in the national data base.

When the Follow-up is being completed for the first time on a particular patient, the following general identifying information must be entered by the transplant surgeon, or transplant coordinator, in the appropriate space(s) in the first row of the Follow-up form:

Transplant Surgeon

Provider Number

Patient Name (Last, First, Middle Initial)

Medicare HIC Number

Date of Transplant

Transplant Follow-up Period

On subsequent Follow-up forms for the same patient, this identifying information will be entered by staff at the NCC. If an error should appear in this row of data, please draw a line through the erroneous information and insert the correct information above it, if known. A ballpoint pen should be used for this and all other portions of the Follow-up form to ensure a readable copy.

The information supplied under Patient Status, Graft Status, and Other is to be for the follow-up period shown at the end of the first row of the Follow-up form. When the Follow-up form is completed for the first, or initial, time, this follow-up period must be entered by the transplant surgeon or transplant coordinator completing the form. The transplant follow-up period is a 1-digit number, as follows:

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Transplant Follow-up Period	Interval Post-Transplant
1	Date of transplant to date of hospital discharge, or date of death if it occurred during the hospital stay
2	Date of hospital discharge to 6 months post-transplant
3	7 months post-transplant to 1 year post-transplant
4	1 year post-transplant to 2 years post-transplant
5	2 years post-transplant to 3 years post-transplant

and yearly thereafter

All data elements in Patient Status, Graft Status, and Other must be answered. If a particular question does not apply to a specific patient, enter "NA" for "not applicable."

Below is an item-by-item description of how to complete each data element under Patient Status, Graft Status, and Other.

DATA ELEMENT	COMPLETION INSTRUCTIONS
PATIENT STATUS	
(10) Is Patient Living At Time of this Follow-up?	If the patient is alive when the Follow-up is completed, check the space under "YES." If the patient is deceased, check the space under "NO."
(11) If Not Living, Give Date of Death (Mo)__ __ (Day) __ __ (Yr) ____	If the patient is not living, enter the month, day, and year the patient died, using a 6-digit number; e.g., March 7, 1981 would be shown as (Mo) 0 3 (Day) 0 7 (Yr) 8 1 .
(12) Is Patient Lost to Follow-up at Time of this Follow-up?	If the whereabouts of the patient are unknown to the transplant surgeon or other physician responsible for

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follow-up data, the patient is considered "lost to follow-up." In that case, check the space under "YES." Otherwise, check the space under "NO."

(13) If Lost to Follow-up, Give Date Last Seen:
(Mo) __ __ (Day) __ __ (Yr) __ __

If the patient is lost to follow-up, enter here the 6-digit number representing the date the patient was last seen by the transplant surgeon or other physician completing the Follow-up. Example: November 14, 1982, would be shown (Mo) 1 1 (Day) 1 4 (Yr) 8 2.

(14) If Patient is Living, Enter Rehabilitation Code from Table A, Attached:

— —

Attached to or on the reverse of the Follow-up form is Table A, entitled "Rehabilitation Codes." The code number must be entered on the Follow-up unless the patient has died.

(15) Was the Patient Transferred to Another Physician or Dialysis Facility?

(A) Physician Name
(B) Provider Number
(C) Date Transferred

If the patient is no longer followed by the transplant surgeon or original transplant center and is followed by a different physician (perhaps a nephrologist) the name of this physician must be entered in (A). If this physician is associated with a renal provider, that number must be entered in (B). The 6-digit date that the patient was transferred to this physician/facility is to be entered in (C). (This should be a 6-digit date as described earlier.)

(This physician will then become the person to whom the NCC will send subsequent Follow-ups for completion. The name of the surgeon who performed the transplant, however, will always be the only name shown at the top of the Follow-up in the row of identifying information.)

GRAFT STATUS

(16) Was Dialysis Performed During this Follow-up Period?

If the patient received one or more dialysis treatments during this follow-up period, the space under "YES" must be checked. Otherwise, check the space under "NO."

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(17) Did Graft Fail During this Follow-up Period?

If, in the opinion of the transplant surgeon or other physician completing the Follow-up, the graft failed during this follow-up period, check the space under "YES." Otherwise, check the space under "NO."

(18) If Yes, Give Date of Failure
(Mo) __ __ (Day) __ __ (Yr) __ __

If the graft failed during this follow-up period, enter the 6-digit number representing the date the graft failed. This date should be entered as described earlier.

(19) Date of Graft Failure Was Determined by:

If the graft failed during this follow-up period, the method used to reach this determination must be indicated under "YES" or "NO":

(A) Patient Receiving an Additional Transplant

(A) Check "YES" if patient received an additional transplant during the follow-up period. Otherwise, check "NO."

(B) Patient Returning to Regular Course of Dialysis

(B) Check "YES" if patient returned to a regular course of dialysis during the follow-up period. Otherwise, check "NO."

(C) Other

(C) Check "YES" if the date of graft failure was determined by other than (A) or (B) above, and specify in item (26) Remarks the method by which the date of graft failure was determined. Otherwise, check "NO."

(20) If Graft Failed, Enter Cause of Transplant Failure Code from Table B, Attached:

(A) Primary: __ __ __

(B) Secondary: __ __ __

The primary cause of transplant failure means the immediate reason the transplant failed. Attached to or on the reverse of the Follow-up is Table B, entitled, "Cause of Transplant Failure Codes." These are 2-digit codes (e.g., 01, 15). When entering the 2-digit code, use the first two spaces provided (e.g., Code 02 would be shown 0 2 __. Note, however, that Code 21 is divided into six categories (21A through 21G). The suffix letter must also be entered (e.g., Code 21C would be shown 2 1 C.)

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(21) Was Graft Removed During this Follow-up Period?

If the transplanted graft was removed during this follow-up period, check the space under "YES." Otherwise, check the space under "NO."

(22) If Yes, Give Date of Removal:
(Mo) __ __ (Day) __ __ (Yr) __ __

If the transplanted graft was removed during this follow-up period, enter the 6-digit number representing the date it was removed. This date must be entered as described earlier.

OTHER

(23) Immunosuppressive Therapy During This Follow-up Period:

(A) Imuran (Azathioprine)

(B) Cytoxan

(C) Prednisone

(D) Antithymocyte Globulin

(E) Irradiation

(F) Solumedrol

(G) Cyclosporin A

(H) Other: Specify:

Immunosuppressive therapy given the patient during this follow-up period must be described in this part of the Follow-up. Check the appropriate space under "YES" or "NO" for each drug listed. If immunosuppressive drugs other than those listed were administered during this follow-up period, check "YES" for Other and specify (please print) the name(s) of the drug(s).

(24) Were There Episodes of Clinical Rejection During this Follow-up Period?

The definition of clinical rejection is left largely to the discretion of the physician. In general, a decline in renal function unexplained by obstruction, renal artery stenosis, etc., of sufficient magnitude to require an increase in immunosuppressive drugs is clinical rejection. On the other hand, renal function may deteriorate in some

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	patients who are not treated with increased amounts of immunosuppressive drugs because of infection, cancer, etc. This should also be considered clinical rejection.
(25) Serum Creatinine	The maximum (highest) serum creatinine reading during this follow-up period must be entered in the appropriate spaces. This figure should be carried to one decimal place.
(A) Maximum Reading During this Follow-up Period: __ __.__	
(B) Most Recent Reading During this Follow-up Period: __ __.__	The most recent serum creatinine reading during this follow-up period must be entered in the appropriate spaces. This figure should be carried to one decimal place.
(26) Remarks	Use this space to enter information, if necessary, for item 19(C). Also, this space may be used to enter additional information on any of the data elements appearing on the Follow-up form.

The person completing the Follow-up form must enter his/her name and the date on appropriate lines at the bottom of the form. Thus, questions about the information provided on the form can be directed to the appropriate individual.

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ESRD Death Notification, HCFA-2746

Complete the ESRD Death Notification, HCFA-2746, within 2 weeks of the date of death. If the patient was a dialysis patient, the dialysis facility last responsible for the patient's maintenance dialysis (or home dialysis) must complete this form. If the patient was a transplant patient, the transplant center is responsible for completing this form.

Mail the original (GREEN) copy and the second (YELLOW) copy to the Network.

Retain the last (WHITE) copy at the provider.

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ESRD DEATH NOTIFICATION

END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

Form Approved
OMB No. 0938-0164

1. PATIENT'S LAST NAME	FIRST	MI	2. HEALTH INSURANCE CLAIM NUMBER

3. PATIENT'S COUNTY OF RESIDENCE*	4. STATE	5. DATE OF BIRTH	6. DATE OF DEATH
	_ _	_ _ | _ _ | _ _ Mo. Day Yr.	_ _ | _ _ | _ _ Mo Day Yr

7. PROVIDER NAME AND ADDRESS (CITY AND STATE)

8. PROVIDER NUMBER	9. PLACE OF DEATH *(Check one)*	10. WAS AN AUTOPSY PERFORMED?
	1 ☐ Hospital 3 ☐ Home 2 ☐ Dialysis facility 4 ☐ Other	1 ☐ Yes 2 ☐ No

11. CAUSES OF DEATH *(Place number from the List of Causes in the spaces provided).*

Primary Cause ____

Secondary Causes ____, ____, ____, ____

LIST OF CAUSES

01 Pericarditis *(Including cardiac tamponade)*
02 Myocardial infarction, acute
03 Cardiac *(Other than 01 or 02)*
04 Cerebrovascular *(Including spontaneous subdural hematoma)*
05 Embolism, air
06 Embolism, pulmonary
07 GI hemorrhage
08 Vascular access hemorrhage
09 Hemorrhage *(Other than 04, 07, or 08)*
10 Pulmonary infection
11 Septicemia
12 Viral hepatitis
13 Infection *(Other than 10, 11, or 12)*
14 Hyperkalemia
15 Pancreatitis
16 Malignancy
17 Withdrawal from dialysis
18 Suicide
19 Accidental death, treatment related *(Other than 05)*
20 Accidental death not treatment related
21 Unknown cause
22 Other *(Specify in Remarks)*

12 IF A MALIGNANCY WAS PRESENT AT DEATH, INDICATE THE YEAR DIAGNOSED, SITE, AND TYPE OF EACH PRIMARY.

1. _ _ Yr. _ _ _ _ _ _ _ _ _ _ Site
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Type

2. _ _ Yr. _ _ _ _ _ _ _ _ _ _ Site
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Type

13. IF DECEASED RECEIVED A TRANSPLANT

1. Date of most recent transplant

_ _ \| _ _ \| _ _ Mo Day Yr

2. Was kidney functioning *(patient off dialysis)* prior to death?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

3. Did transplant patient resume outpatient chronic maintenance dialysis prior to death?

1 ☐ Yes 2 ☐ No

14. REMARKS

SIGNATURE DATE

NOTE *If patient residence is not in a specific county, enter incorporated city or township.

This report is required by law (42 U.S.C. 426, 20 CFR 405, Section 2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 U.S.C. 5520, 45 CFR Part 5a).

FORM HCFA 2746(6-81) (Formerly HCFA-600-2)
PRIOR EDITIONS MAY BE USED

ESRD MIS COPY
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Department of Health and Human Services
Health Care Financing Administration

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INSTRUCTIONS FOR COMPLETING THE ESRD DEATH NOTIFICATION, HCFA-2746

ITEM	PROCEDURE
1	Patient's Last Name, First, and Middle Initial Enter the patient's last name, first name, and middle initial as it appears on the Health Insurance Card or other official SSA notification.
2	Health Insurance Claim Number Enter the patient's health insurance number as it appears on the Health Insurance Card or other official SSA notification.
3	Patient's County of Residence Enter the patient's county of residence. If the patient's residence is not a specific county, enter the incorporated city or township.
4	State Enter the two-letter United States Postal Service abbreviation for State in the space provided; e.g., MD for Maryland, NY for New York.
5	Date of Birth Enter the date in month, day, and year order, using a six-digit number; e.g., 07/02/50, for July 2, 1950.
6	Date of Death Enter the date of death in month, day, and year order, using a six-digit number; e.g., 07/14/84, for July 14, 1984.
7	Provider Name and Address (City and State) Enter the complete name, city, and State in which the provider is located.
8	Provider Number Enter the six-digit Provider Number assigned by

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the Health Care Financing Administration.

9 Place of Death

Check the one block which indicates the location of the patient at death. In-transit deaths or dead on arrival (DOA) cases are to be indicated by checking "Other."

10 Was an Autopsy Performed

Check the one block which indicates whether or not the patient has been autopsied.

11 Causes of Death

Select from the list of causes the primary cause of death and the secondary or underlying causes of death and enter the appropriate numbers in the spaces provided. If Item 11-22, "Other," is selected as either a primary or secondary cause of death, specify that cause in the Remarks section, Item 14. Enter all secondary causes in the order of their contribution to death; i.e., cause of greatest contribution to death first space, etc.

12 If a Malignancy was Present at Death

If a malignancy was present at death indicate the year diagnosed, site, and type of each primary. Ten spaces are provided for site and fifteen for type. If the space provided is not sufficient, please abbreviate. Do not enter two characters in one space or use more spaces than are provided. Additonal clarifying information may be entered in the Remarks section, Item 14.

13 If Deceased Received a Transplant

If the Deceased had ever received a transplant, complete Items 13-1, 13-2, and 13-3.

1. Date of Most Recent Transplant

   Enter the date of the most recent transplant in month, day, and year order using a six-digit number; e.g., 07/14/76, for July 14, 1976. If the day is unknown,

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enter "00" as place holders.

2. Was Kidney Functioning Prior to Death
Check the block which indicates whether or not the graft was functioning at the time of death or, if not known, check "Unknown."

3. Did Transplant Patient Resume Outpatient Chronic Maintenance Dialysis Prior to Death
Check the block which indicates whether or not the patient was returned to chronic maintenance dialysis prior to death.

If the deceased had never been transplanted, enter "NA" (not applicable) in Item 13 to indicate that absence of data was not an oversight.

14 Remarks
Enter any additional clarifying information in this space.

Signature
The signature of the patient's physician or the facility representative completing the Death Notification should be entered.

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